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F 000	INITIAL COMMENTS An abbreviated survey (KY #22970) was conducted on 03/31/15 through 04/02/15 to determine the facility's compliance with Federal requirements. KY #22970 was unsubstantiated with regulatory violations identified.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide care by qualified persons in accordance with each residents written Plan of Care for one (1) resident (Resident #2) in the selected sample of three (3). Resident #2 was required to have a full body pillow per the Comprehensive Plan of Care and Nurse Aide Data Sheet. The findings include: Review of the facility's policy titled, " Comprehensive Care Plan " dated, 04/03/13, revealed it is the facility's policy that residents will have a plan of care for assessed needs and the care plan will be communicated to staff for use in providing direction of care for the residents. Review of Resident #2's medical record revealed the facility admitted the resident on 06/26/14, with diagnoses which included Alzheimer's Disease,	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/26/2015

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Senile Osteoporosis, Edema and Unspecified Psychosis. Review of the Significant Change assessment completed 05/25/14, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) scored at a (99) which indicated the resident was unable to complete the interview.

Review of the Physician's Orders dated 03/01/15 through 03/31/15 revealed Resident #2 required to be positioned in bed with a body pillow when in bed.
Review of the Comprehensive Plan of Care, dated 02/04/15, revealed due to current pressure ulcers related to medical conditions and functional factors the resident was at risk for further skin breakdown and Resident #2 had interventions included treating the wounds per Physician's Orders, pressure reducing air mattress to bed, and pillow between the knees when in bed and up in wheelchair. Further review of the Nurse Aide Data Sheet dated 1/14/15 in section titled, Pressure Reduction/Positioning, revealed Resident #2 to require a body pillow at all times in bed.

Observation on 04/01/15 at 10:24 AM, revealed Resident #2 was in bed lying on his/her left side with no pillows between the legs and no body pillow in place. Observation at 2:55 PM revealed Resident #2 to be lying in bed still with no body pillow or pillow between the knees. Additional observation on 04/01/15 at 3:40 PM revealed Resident #2 lying in bed with no body pillow in place, a pillow under his/her head with no other pillows on the bed and a blanket in between the knees lying on his/her right side. Observation on 04/02/15 at 11:15 AM revealed Resident #2 had regular pillows while in bed under left side, head

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and between knees with no body pillow.

Interview on 04/01/15 at 3:40 PM with Certified Nursing Assistant (CNA) CNA#3 and CNA #5 revealed the Nurse Aid Data Sheet indicated Resident #2 was to have a body pillow for positioning while in bed at all times. CNA#3 stated that Resident #2's family takes the body pillow out of the facility to be laundered per family choice. CNA #5 stated there was not an alternate body pillow for Resident #2 to use when the body pillow was out of the facility being laundered by family. The CNA's further stated the body pillow was a big pillow that wraps around the whole resident and normally CNA's place regular pillows all around Resident #2 when the body pillow was not there. Interview further revealed the CNA's were not sure how long Resident #2 had been without the body pillow and stated that they were the CNA's assigned to assist Resident #2 and did not know how they missed placing pillows around Resident #2 that day.

Interview on 04/02/15 with the Director of Nursing (DON) at 12:18 PM revealed it was her expectation for any staff member that sees and/or is informed that a family member takes Resident #2's body pillow that regular pillows are to be used while the body pillow was not available. She was to be notified and a notation would be made when the body pillow was taken from the facility. The DON stated a total of three more body pillows were purchased on 04/02/15 so Resident #2 would have an alternate.. The DON stated the CNA's and nursing should have provided pillows at all times for bed positioning. She further stated that the care plan should be checked often due to changes that can happen with the residents daily and stated it was her expectation that care plans

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F 282	Continued From page 3 be revised and followed to ensure proper care for the residents. Interview with the Administrator 04/02/15 at 12:09 PM revealed it was her expectation that staff should communicate when the resident's family takes Resident #2's body pillow out of the facility so pillows can be placed on the bed to use as an alternate. She further stated it was her expectation for staff to follow the care plan and if an intervention was in place then staff need to follow it.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for two (2) of three (3) sampled residents (Resident #1 and Resident #2). Resident #1 was observed on an air mattress without the appropriate setting. Resident #2 had stage IV pressure ulcers to the	F 314		

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hip and coccyx and failed to have a body pillow in place for positioning as ordered.

The findings include:

Review of the facility's policy/procedure titled, "Preventive Skin Care Program", revised 12/19/13, revealed the purpose is to promote dignity and enhance the resident's quality of life by maintaining or restoring resident's skin integrity and implement preventative measures through ongoing monitoring of residents at risk for skin breakdown.

Review of the facility's policy titled, "Pressure Ulcer", dated as revised 12/19/13, revealed it is the policy of the facility to promote the healing and enhance the resident 's quality of life; all pressure ulcers and other wounds shall receive treatment. Further review revealed documentation to include, wounds would be monitored on an ongoing basis and the treatment plan would be altered as indicated.

1. Record review revealed the facility readmitted Resident #1 from the hospital, on 03/26/15, with diagnosis to include Pseudomonas urosepsis, improved, severe hypotension, acute renal failure and Chronic Kidney Disease (CKD) stage 4, complete immobility, recurrent hyperkalemia, history of tremors and peripheral neuropathy in addition to Dementia, anxiety, hypertension, depression, and hypothyroidism. Review of the significant change Minimum Data Set (MDS), dated 01/07/15, revealed the facility assessed Resident #1's cognition as cognitively impaired with a Brief Interview of Mental Status (BIMS) score of four (04) which indicated the resident was not interviewable.

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Record review of the Interdisciplinary Care Plans for Pressure ulcers Risk Analysis/Care Plan, dated 03/26/15, revealed the resident was at risk for development of pressure ulcers. In addition, the pressure relief protective devices listed included special mattress type: air mattress.

Record review of the Nurse Aide Data Sheet, undated; however, Registered Nurse (RN) #2 wrote the date 02/24/15 on the form in the presence of the surveyor, revealed Resident #1 should have a specialty air mattress.

Record review of the physician's orders, dated 03/26/15, revealed an order for "air mattress to bed". In addition, review of the physician's orders, dated 03/30/15, revealed an order to " cleanse back and buttocks every shift with soap and water, apply Lotrisone and change to as necessary (PRN) when healed. " In addition, review of the physicians orders, dated 03/31/15, revealed an order for Lomotil one tablet three times daily as needed for diarrhea.

Review of the Weekly Skin Observations form for Resident #1, revealed a narrative note describing skin conditions observed on 03/11/15; however, no further skin observations were documented.

Record review of the Nursing intervention Flow and Treatment Records, dated 02/26/15 and Feb 2015, revealed an intervention for alternating air pressure mattress to include staff initials on each shift. However, Nursing Intervention Flow forms dated 01/15 and 02/15 revealed an intervention for "pressure reduction mattress: air" with an " FYI " in the frequency column and no staff initials.

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Review of the Joerns Healthcare User-Service Manual for Dermfloat LAL model Mattress, undated, revealed documentation to include the DermaFloat LAL is a unique therapy system that provides pressure relief by combining low air loss with pulsation. Low air loss therapy has been demonstrated to reduce the risk of pressure ulcers. Operation-The unit starts up in Standby. Press the Power button to inflate the mattress. When the Standby light is on, it may indicate there has been a power interruption and the therapy control unit is ready to be turned back on. Press the Power button and reset the preferred mode of therapy and comfort level.

Observations on 03/31/15 at 3:15 PM and 3:45 PM of Resident #1, revealed the resident in bed, fingernails clean, some periorbital redness with no drainage. Resident answered questions appropriately, Joerns air mattress on bed and on " standby " .

Observations on 04/01/15 at 10:25 AM, 12:20 PM, 1:40 PM, 2:15 PM, 3:45 PM and 4:40 PM revealed Resident #1 in bed, Joerns air mattress on bed and on " standby " mode .

Observation on 04/02/15 at 9:10 AM, revealed Resident #1 in bed with air mattress on and cycling.

Interview on 04/01/15 at 4:40 PM, with Certified Nurse's Aide (CNA) #1, revealed she was not responsible for adjusting or documenting air mattress settings.

Interview on 04/01/15 at 4:45 PM, with CNA #4, revealed she was not responsible for adjusting or

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documenting air mattress settings. The CNA stated she would notify the nurse if the mattress was deflated or turned off but would not monitor or change settings.

Interview on 04/01/15 at 5:50 PM, with Licensed Practical Nurse (LPN) #1, revealed it was the nurse's responsibility to check mattress settings. She stated she was Resident #1's nurse and she would normally check the mattress setting but "I just got her and I am doing resident accuchecks". The Director of Nursing then entered Resident #1's room and asked the resident " have you been feeling your mattress move? " Resident #1 responded, " No, I have not been feeling it " .

A phone interview on 04/01/15 at 4:30 PM with a Customer Service Representative for Joerns, revealed the mattress should be on a therapy mode instead of constantly on standby mode. She stated the mattress would not pose a threat to the resident on standby mode but would not be providing the intended therapy.

Interview on 04/02/15 at 9:30 AM, with RN #2, revealed the mattress type was recorded on the treatment record, the charge nurse was responsible to initial on the Treatment Administration Record (TAR) to confirm the correct mattress, and settings were in place and functioning. In addition, the nurse stated the mattress should not be on "standby" all day unless the resident was not in the bed.

Interview on 04/02/15 at 9:50 AM with RN #1, who began working at the facility on 03/19/15, revealed air mattresses should be turned on and working. In addition, the RN said she was provided an in-service this morning on checking

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resident rooms each day to ensure equipment was on and functioning. She stated the nurse should check the settings of the mattresses and CN 's should alert the nurse if a mattress was deflated. RN #1 stated she was unsure where to document mattress settings.

Interview on 04/02/15 at 12:18 PM, with the Director of Nursing (DON), revealed any staff that entered the resident's room, whether it is dietary, aides or nurses should have glanced at the bed to ensure the mattress was on the proper setting and functioning. In addition, she said staff was provided an in-service due to the concern of resident #1's mattress setting being left on standby. The DON stated CNA's were not responsible for changing an air mattress bed setting mode and know the mattress should not be on standby. She expected CNA's to notify the nurse and ensure the problem was reported and maintenance would monitor the information using a care tracker form and notify the DON and Administrator.

Interview on 04/02/15 at 12:09 PM with the Administrator, revealed the nurses were responsible for checking mattress settings and she expected staff to check mattress settings every shift, in addition a mattress should not be left on standby all day. The administrator said shift checks should be documented on the TAR and the nurse's initials would indicate the mattress is in place and settings were checked. She said the TAR, dated 03/26/15, was changed yesterday from "FYI" to shift times as a reminder for staff to check the mattress and settings each shift.

Review of the facility's "Weekly Skin

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Observations" form, dated 12/19/13, revealed directions for form completion to include describe skin conditions observed, mark the affected area on the diagram. If none present, note. Specific wound measurements to be recorded on Admission, New Onset, and Weekly Wound Analysis. Notify physician of conditions of new onset or if indicated by change in condition.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 06/26/14, with diagnoses which included Alzheimer ' s disease, Senile Osteoporosis, Edema and Unspecified Psychosis. Review of the Significant Change assessment completed 05/25/14, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) scored at a (99) which indicated the resident was unable to complete the interview. Continued review of the MDS revealed the facility assessed Resident #2 to require extensive assistance with transfers and ambulation did not occur during the assessment period.

Review of the Physician ' s Orders dated for 03/01/15 through 03/31/15 revealed Resident #2 required to be positioned in bed with a body pillow when in bed.

Review of the Weekly Wound Analysis dated 03/10/15, revealed Resident #2 had a Stage IV Pressure Ulcer to the left hip which measured 2 centimeters (cm) in length by .4 cm width and 1.8 cm in depth. Continued review of the Wound Analysis revealed Resident #2 also had a Stage IV Pressure Ulcer to the coccyx unmeasured on the form, and stated contributing factors were due to immobility. Review of the following Wound Analysis, dated 03/19/15 and completed by the

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Wound Nurse, revealed the left hip to be a Stage II measuring .8 cm in length, 2 cm width and .2 cm depth. Further review for the Wound Analysis on the coccyx revealed the area a Stage II measuring 1.3 cm length, 1 cm width and less than .1cm depth with healthy edges with stable wound beds.

Review of the Comprehensive Plan of Care, dated 02/04/15, revealed due to current pressure ulcers related to medical conditions and functional factors the resident was at risk for further skin breakdown and Resident #2 had interventions included treating the wounds per Physician's Orders, pressure reducing air mattress to bed, and pillow between the knees when in bed and up in wheelchair. Further review of the Nurse Aide Data Sheet dated 1/14/15 in section titled, Pressure Reduction/Positioning, revealed Resident #2 to require a body pillow at all times in bed.

Observation on 04/01/15 at 10:24 AM, Resident #2 was in bed lying on his/her left side with no pillows between the legs and no body pillow in place. Observation at 2:55 PM revealed Resident #2 to be lying in bed still with no body pillow or pillow between the knees. Additional observation on 04/01/15 at 3:40 PM revealed Resident #2 lying in bed with no body pillow in place, a pillow under his/her head with no other pillows on the bed and a blanket in between the knees lying on his/her right side. Observation on 04/02/15 at 11:15 AM revealed Resident #2 had regular pillows while in bed under left side, head and between knees with no body pillow.

Interview on 04/01/15 at 3:40 PM with Certified Nursing Assistant (CNA) CNA#3 and CNA #5

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revealed on the Nurse Aid Data Sheet Resident #2 is to have a body pillow for positioning while in bed at all times. CNA#3 stated that Resident #2 ' s family takes the body pillow out of the facility to be laundered per family choice. CNA#5 stated there is not alternate body pillow for Resident #2 to use when body pillow is out of the facility being laundered by family. The CNA ' s further stated body pillow is a big pillow that wraps around the whole resident and normally CNA ' s place regular pillows all around Resident #2 when body pillow is not there. Interview further revealed CNA ' s were not sure how long Resident had been without the body pillow and stated that they were the CNA ' s assigned to assist Resident #2 and did not know how they missed placing pillows around Resident #2 that day.

Interview on 04/01/15 at 3:40PM with Director of Nursing (DON) revealed Resident #2 did not have a pillow in between his/knees as care plan indicated Resident needed. The DON showed the folded blanket used in between Resident #2 ' s legs and stated " that should be okay to use as a pillow in between the knees to use as a protection against bone to bone " . The DON further stated the full body pillow is used to prevent further skin breakdown and positioning in the bed. She further stated the Resident did not have an alternate body pillow that could be used when the family took the full body pillow out of the facility. In addition, she stated the facility had no communication as to how long the body pillow had been out of the facility. The DON further stated that it is not care planned for the facility to use regular pillows instead of the body pillow however, she stated that is what staff use when body pillow is not available and stated there should have been pillows on the resident ' s bed

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for purpose of positioning.

Interview on 04/01/15 at 4:00 PM with Certified Occupational Therapy Assistant (COTA) revealed Resident #2 was evaluated and needed the body pillow for positioning while in bed to take pressure off of the acromion processes and his/her bottom and also needed a pillow between the knees to separate his/her lower extremities as well. COTA revealed there should be an alternate body pillow utilized when body pillow was taken out of the facility.

Interview on 4/02/15 at 10:18 AM with Physical Therapy Assistant (PTA) revealed Resident #2 was supposed to have the body pillow in bed at all times for bed positioning to alleviate pain, prevent skin breakdown and to assist with comfort for his/her body shape. She further revealed it was recommended to utilize the body pillow after previous attempts had failed with other devices due to his/her posture. The PTA further stated that Resident #2 had several bony prominences and utilization of the body pillow was needed.

Interview on 04/02/15 at 12:18 PM with the Director of Nursing (DON) revealed it is her expectation for any staff member that sees and/or is informed that a family member takes Resident #2's body pillow that regular pillows are to be used while the body pillow is not available and she is to be notified and notation will be made when body pillow is taken from the facility. The DON stated a total of three more body pillows were purchased 04/02/15 so Resident #2 will have an alternate when the other is not available to resident. The DON stated CNA's and nursing should have provided pillows at all times for bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185309	A. BUILDING _____ B. WING _____	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VIEW HEALTH & REHAB CENTER, INC	718 GOODWIN LANE LEITCHFIELD, KY 42754

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 positioning. Interview on 04/02/15 at 12:09 PM with the Administrator revealed it was her expectation that staff should communicate when resident's family takes Resident #2's body pillow out of the facility or if body pillow is being laundered so pillows can be placed on the bed to use as an alternate.	F 314		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the weekly skin assessments were accurately documented for three (3) residents (Resident #1, #2 and #3) in the selected sample of three (3). The findings include:	F 514		

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F 514	Continued From page 14	F 514		

Review of the weekly skin observation form dated 12/19/13 revealed directions to describe skin conditions observed and to mark the affected area on the diagram.

1. Record review revealed the facility readmitted Resident #1 from the hospital, on 03/26/15, with diagnosis to include Pseudomonas urosepsis, improved, severe hypotension, acute renal failure and Chronic Kidney Disease (CKD) stage 4, complete immobility, recurrent hyperkalemia, history of tremors and peripheral neuropathy in addition to Dementia, anxiety, hypertension, depression, and hypothyroidism. Review of the significant change Minimum Data Set (MDS), dated 01/07/15, revealed the facility assessed Resident #1's cognition as cognitively impaired with a Brief Interview of Mental Status (BIMS) score of four (04) which indicated the resident was not interviewable.

Record review of the Weekly Skin Observations form for Resident #1, revealed a narrative note describing skin conditions dated 03/11/15; however, no further skin observations were documented or marked on the diagram.

2. Record review revealed the facility readmitted Resident #2, on 08/09/10, with diagnosis to include Alzheimer's disease, depressive disorder, senile, osteoporosis, hypertension, unspecified psychosis, and edema. Review of the quarterly Minimum Data Set (MDS), dated 01/23/15, revealed the facility assessed Resident #2's cognition as severely impaired which indicated the resident was not interviewable. In addition, the facility assessed the resident at risk for the development of pressure sores.

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F 514	Continued From page 15	F 514		

Record review of the Weekly Skin Observations form for Resident #2, revealed narrative notes describing skin conditions dated 03/03/15, 03/10/15 and 03/24/15; however no information was marked on the diagrams dated 03/03/15 and 03/10/15.

3. Record review revealed the facility readmitted Resident #3, on 11/12/13, with diagnosis to include heart failure, diabetes mellitus, hyperlipidemia, cerebral palsy, coronary artery disease, hypertension, anxiety disorder, pressure ulcer hip, dysphagia, and abnormal posture. Review of the quarterly Minimum Data Set (MDS), dated 01/10/15, revealed the facility assessed Resident #3's cognition as cognitively intact with a BIMS score of twelve (12). In addition, resident #3 was admitted with one (1) stage II and two (2) stage IV pressure ulcers.

Record review of the Weekly Skin Observations form for Resident #3, revealed narrative notes describing skin conditions; however, no information was marked on the diagrams.

Interview on 04/02/15 at 9:30 AM with RN #2, revealed weekly skin observations were kept in treatment binder on treatment cart and residents were scheduled for skin observations weekly on a specific day and shift. The nurse that completes the weekly observation should assess from head to toe and document any open areas, bruises, redness, edema, and anything out of the ordinary. We use the previous week's observation to compare for improvement or worsening. We were not expected to use this form to measure but we were expected to mark the areas on the diagram. Her understanding was they should use

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F 514	Continued From page 16	F 514		

the form to include both narrative description of the area and mark the area on the body diagram. RN #2 viewed Resident #1's skin observation forms and stated, "The diagram is not circled, and those forms are not complete" .

Interview on 04/02/15 at 9:50 AM with RN #1, revealed weekly skin observations were completed per an assignment schedule/sheet and a head to toe assessment should be completed and anything that was new should be noted. She stated her understanding was to make a notation and mark the diagram on the form per the documentation instructions listed at the top of the form.

Interview on 04/02/15 at 12:18 PM with the DON, revealed staff should complete weekly skin assessments, documented on the weekly skin observation form, marked on the diagram grid when there is a new area, and compared with previous documentation. In addition, she stated there should be an indicator mark of an "x" or a "circle" to the area on the diagram as well as good documentation that describes color, size etc. and followed by treatment if treatment were necessary.

Interview on 04/01/15 at 11:00 AM with the Administrator, revealed staff should follow the directions on the top of the form "weekly skin observations".